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COMPLICATIONS

DURING AND AFTER THE OPERATION IN A FEW RECENT CASES OF

ABDOMINAL AND PELVIC SURGERY.[1]

BY

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While an experienced gynecologist can usually diagnosticate pathological conditions in the pelvis or abdomen that indicate the necessity for an operation, all successful laparatomists are constantly reminded that it is seldom if ever possible, until the abdomen has been opened, to know just what complications are to be treated in order to complete the operation and save the life of the patient. It is then not always possible to do so. It is exceptional that we find just what we had expected. We anticipate complications that may jeopardize the life of the patient, but the operation proves to be a simple affair; again, we open the abdomen expecting to complete the operation without difficulty, but conditions are met with that make the procedure a dangerous one that severely taxes the ingenuity of the most experienced laparatomist. Hence the necessity of never attempting such work until we are thoroughly prepared, theoretically and practically, to treat successfully the various complications that we may encounter. If the operator knows how to treat correctly every abnormal condition in the abdomen or pelvis that surgery can remove, his failure to make an absolutely

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presented by the author

correct diagnosis is of no serious consequence, if he does honest work. But "there is too much laparatomy done, and too many men are doing it—men who know too little about such work and have but few facilities for operating." The desire to be known as an abdominal surgeon and to report a series of sections seems to sometimes control the intelligence or the honor of the surgeon, and women with comparatively healthy ovaries and tubes are mutilated beyond redemption, and many of them are made invalids or die, because the operator is ignorant of the correct principles and details that every successful laparatomist must know.

The patients who recover from the immediate effect of the operation are at once published in advocacy of successful laparatomy, but we hear nothing of the incomplete operations or the sequelæ that are developed later, nor have we always an opportunity to know anything about the numerous cases that die during or soon after the operation. The operator is too enthusiastic and energetic in his efforts to convince other women—probably a little nervous, but otherwise comparatively healthy, with no pelvic exudates or adhesions—that their ovaries and tubes are useless organs, and *dangerous ones too*, for, if not hurriedly removed, a *pus tube may rupture* and cause death within a few hours. We are all familiar with such cases, and there is probably not a city in the country, where several men are doing abdominal surgery, that has not one or more operators of which the above is a correct prototype.

It is no uncommon occurrence for a woman to consult me, saying that a physician had advised the removal of her ovaries and tubes because of extensive adhesions, exudates, or pus tubes, where an examination showed an entire absence of every pathological condition that her pseudo-laparatomist had so vividly pictured to her. I have written several papers in condemnation of reckless laparatomy, and have reported many cases in proof of the correctness of the position I have assumed, no one of which has been controverted. I could report many more, but the evil is so manifest to all honest and successful abdominal surgeons that it would be a waste of time.

I am pleased to see that many men, with the courage of their convictions, have tried to teach the medical profession

the wisdom of conservative gynecology and the evil of reckless and selfish mutilation of women. Among those who deserve especial commendation may be mentioned Polk, Emmet, Mundé, and Coe, of this country, and Wells, Keith, Doléris, and Apostoli, of Europe. Just here I wish to emphasize that I am an earnest believer in laparatomy in properly selected cases, and I know of no department of surgery that has achieved such results or deserves more universal approval and praise.

I am doing a good deal of abdominal surgery, but I operate for the removal of disease where no other treatment could so certainly cure the patient. And I have probably had my share of success, for I have had no death, and practically no untoward symptom for about one year, though I have operated on women where the conditions indicated an unfavorable prognosis.

"I do not believe that reported recoveries in simple cases of laparatomy always indicate superior or unusual skill in the operator; and such reports are of little value to the medical profession, and may indirectly result in the death of many women by influencing ignorant men, with no facilities for such work, to attempt it because of its apparent simplicity."

I will therefore report a few selected cases from my recent work where there was some unusual condition, or troublesome complication, to contend with during or after the operation. The study of such cases teaches us to do better work by learning how to treat complications and prevent accidents.

Case I.—Miss M., age 24, was referred to me by a well-known surgeon of Missouri, who had diagnosticated pelvic abscess on the left side. She was always apparently in excellent health until July, 1891, and had never suspected any tumor or disease in the pelvis or abdomen. At this time she began to suffer severely in the left inguinal region, had accelerated pulse and several degrees of increased temperature. A tumor could be distinctly outlined on the left side of the pelvis, extending into the abdomen. The pain and fever continued for several weeks, but finally subsided, and she thought she was well and did not examine to learn if the tumor had disappeared. She did not suffer any more and was apparently well until July, 1892, when she had a recur-

rence of the pain and fever, and again noticed the tumor. She suffered intensely and was confined to bed for four weeks, and could not come to Louisville for six weeks. She has lost twenty pounds of flesh, is still feeble, but has no pain or fever and is regaining strength. The uterus is nearly immovable, with a tumor in the left broad ligament which seems to be fixed and connected with the uterus; it extends as high as the umbilicus and over a little to the right of the median line. A correct diagnosis is impossible, but the necessity for a laparatomy is positive.

The abdomen was opened August 20th, 1892. The omentum was thick, showed signs of extensive chronic peritonitis, and was firmly adherent to all the anterior part of the tumor and to the upper surface of the pelvic structures. When the adhesions were separated the omentum was so torn and bruised that I removed it above the level of the umbilicus. The tumor was an embedded broad-ligament cyst, which had not only unfolded the broad-ligament layers of peritoneum, but had stripped this membrane from the posterior pelvic wall to a point above the sigmoid flexure of the colon, separating the layers of the meso-colon so that the mesenteric surface of the bowel was attached to the thin cyst wall. The bowel could be distinctly seen and traced on the anterior surface of the tumor over to the right side, where it dipped into the pelvis and came around behind the womb to the rectum. The uterus was enlarged to three times its normal size, and the peritoneal covering was separated over a large surface from the left side of the body and fundus, thereby exposing its muscular layer. There was no shock, and the patient has made an uninterrupted recovery from the operation.

Case II.—Mrs. W., Kentucky, age 40; married and has several children, the youngest 3 years old. She is anemic and sallow; has complained of some pain and pressure in the region of the uterus for six months, but for three months the pain on the right side has been so severe that she has been most of the time confined to bed and has lost considerable flesh. She has not missed her menstrual period until three months ago; since then menstruation has been irregular. The uterus is fixed and there are hard exudates on each side. The tumor is twice the size of a large orange and reaches on

the left side several inches above the pelvic brim. An exploratory laparatomy was performed on March 27th, 1892. A band of omentum, nearly as wide and thick as the hand, was attached to the right broad ligament in the region of the severe pain. It was ligated in two places and divided. The enlarged uterus and the exudates in the pelvis were united in one solid malignant mass. No part of the peritoneal surface of the intestines was adherent to the tumor, but the enlarged uterus, with its neoplastic surroundings, had insinuated itself under the sigmoid flexure of the colon, which was attached by its mesenteric surface across the anterior part of the uterus, after the same fashion as in Case I.

She had no pain after the operation, took no morphia, had a normal pulse and temperature, and went home, a distance of fifty miles, in two weeks. She has had but little pain since and has gained in flesh, but, of course, the growth will continue to increase and will eventually cause death.

Case III.— Mrs. B., Kentucky, age 24; married eight months; was well until three years ago, when she was thrown from a buggy and probably received some internal injury. She recovered from the immediate effects of the fall, but has not felt entirely well since.

Three weeks after marriage she had what was diagnosticated appendicitis and was very sick for several weeks. She had severe pain in the right inguinal region, her bowels could not be moved for ten days, and she vomited a great deal of matter with a very offensive odor. She finally recovered from the immediate effects of the attack, but has had several relapses, and at one time the attending and consulting physicians did not think she could get well. During these attacks her pulse became accelerated, though she had but little, if any, fever. The uterus is in normal position, with some adhesions on the right side. No tumor or enlargement can be found in the pelvis or abdomen, and firm pressure causes no pain. At the earnest request of her husband, a prominent physician, who believed she could not live through another attack, I performed a laparatomy at St. Joseph's Infirmary, June 12th, 1892. An incision three inches long was made in the right linea semilunaris. The omentum was extensively adherent down to the right ovary and tube, and nearly all the

small intestines and some of the cecum and ascending colon were held together by tough peritoneal adhesions, as were also the right ovary and tube. The pelvic, intestinal, and omental adhesions were carefully separated without injury to any organ, but the omentum was so torn that it was necessary to ligate and remove a piece fifteen inches long and several inches wide and to suture an opening above the ligatures. There was but little hemorrhage and no shock, and the patient was taken from the operating room in thirty minutes. A glass drainage tube was used for two days. Before the operation her pulse was 100, but it was not over 90 after it, and on the second day it was 80; it was afterward from 72 to 80. At no time was there an untoward symptom, and she suffered less after forty-eight hours than at any time since the first attack. She returned home, a distance of sixty miles, on the sixteenth day. She has gained flesh and says she is entirely well. The appendix was adherent, but not enlarged or otherwise diseased, and the peritonitis was probably caused by the fall from the buggy.

Case IV.—Miss H., Louisville, age 17; single; began to suffer severe pain in the region of the appendix vermiformis ten days before I saw her in consultation, and had a rapid pulse, and high fever that did not intermit. After the fourth day a tumor could be felt low down in the right inguinal region immediately in contact, and apparently connected, with the ileum. The tumor gradually increased in size, and when I saw her it had extended to the median line and above the umbilicus; her temperature was 105° and her pulse 140. Her bowels moved daily and she had but little tympanites. On August 3d an opening two inches long was made in the right linea semilunaris and nearly a pint of pus discharged, in which was found a fecal concretion, of oval shape, one-third of an inch in diameter and two-thirds of an inch long. It was hard and had a nucleus resembling calcareous matter. The appendix could not be found, and the peritoneal cavity and intestines were shut off from the pus cavity, the outer boundary of which was formed by the abdominal and pelvic walls. It was appendicular in origin, but extraperitoneal. On the second day the pulse and temperature were about normal and remained so. The cavity was packed with iodoform gauze,

but in a few days two gum drainage tubes were substituted and bichloride injections used.

Her recovery was uninterrupted, and the cavity and abdominal wound have closed.

Case V.—Mrs. H., Indiana, age 44; married and has three children; has been well, with the exception of indigestion, until a year ago. She then began to have leucorrhea, the discharge often being in appearance like the menstrual flow. Six months afterward her husband, an excellent surgeon, made an examination and diagnosticated incipient epithelioma, limited mainly to the posterior lip of the cervix uteri. Her condition gradually grew worse, and she was referred to me the 1st of August, 1892. Her general appearance indicates perfect health. Her uterus is retroverted, but not adherent. The epithelioma has extended to part of the anterior lip, and on the posterior vaginal wall down to nearly the bottom of the pouch of Douglas. There is no appearance of systemic infection, or that the disease has involved the uterine adnexa or pelvic glands. The uterus was removed August 15th by vaginal hysterectomy, the broad ligament being clamped with my hysterectomy forceps, which were removed in forty-eight hours. There was no untoward symptom for two weeks, and the patient was sitting up and walking about the room and hall of the Infirmary. She had dismissed her nurse, and on the morning of the fifteenth day another nurse, in charge of convalescing patients, gave her a vaginal douche of two quarts of hot 1 : 2,000 bichloride solution. But little of the water returned, and she immediately suffered intense pain in the pelvis, which in severity was intermittent like labor pains, and at each exacerbation some of the water, which had been forced into the peritoneal cavity, came away. She ceased passing urine through the urethra, and on the morning of the sixteenth day the discharge was nearly all urine, most of which came away during the severe pains. A little urine passed through a retained catheter, the quantity gradually increasing, and after ten days none passed from the vagina, showing that the opening had closed. It was necessary to give morphine hypodermatically every four hours for several days, and occasionally for a week. She had no fever or acceleration of pulse and no symptom of peritonitis.

I will offer no explanation to show how the injection caused an opening in the bladder and peritoneal cavity, and report this case mainly to justify an opinion expressed by me three years ago, that the douche after vaginal hysterectomy is no prevention against septic peritonitis, but may convey pathogenic germs and irritants to the peritoneum by forcing the chemical germicide with necrosed tissue into the pelvic and abdominal cavities.

Case VI.—Mrs. H., Louisville, age 34; married, but has never been pregnant; has for several years suffered such intense and constant pain deep in the pelvis and in the rectum that she has been unable to attend to her domestic affairs. She has been treated by several excellent physicians, none of whom diagnosticated her trouble, or gave relief. There is no disease in the rectum or the uterus, but a tumor of more than fibrous hardness, the size of a turkey egg and movable, can be felt deep in the pouch of Douglas and pressing upon the rectum. A laparatomy was performed August 1st, 1892, and the tumor removed from the folds of the left broad ligament with no connection with the ovary or tube. Recovery was uninterrupted, and she says she is perfectly relieved. By examining the specimen you will see that it is fibroid with extensive calcareous degeneration. While a fibroid tumor with calcareous degeneration in the folds of the broad ligament, having no connection with the uterus, ovaries, or tubes, is not unique, it is so rarely observed that but few laparatomists have probably seen such a case.